

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on April 13, 2004.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the Carisoprodol, Hydrocodone/APAP and Promethazine were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Division has determined that medical necessity fees were the only fees involved in the medical dispute to be resolved. As the treatment listed above were not found to be medically necessary, reimbursement for dates of service from 04-18-03 to 06-04-03 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 20th day of July 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division
PR/pr

NOTICE OF INDEPENDENT REVIEW DECISION

Date: June 15, 2004

MDR Tracking #: M5-04-2549-01

IRO Certificate #: 5242

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by an Orthopedic reviewer (who is board certified in orthopedic surgery) who has an ADL certification. The reviewer has signed a certification

statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Submitted by Requester:

- Admission history and physical, admit date 1/7/01.
- Clinical notes from 1/6/03 to 11/3/03

Submitted by Respondent:

- Operative report, lumbar epidural steroid injection dated 1/22/02
- Operative report, bilateral lumbar facet injections dated 12/4/03

Clinical History

The claimant has a history of chronic low back pain allegedly related to the compensable injury that occurred on or about _____. X-ray report of lumbosacral spine indicated a superior endplate fracture of L1 and CT scan showed a patin canal and no stenosis. Clinical impression at the time of admission to the hospital included superior endplate fracture, low back pain, concussion, cervical sprain.

Requested Service(s)

Carisoprodol, Hydrocodone/APAP, Promethazine for 4/18/03-6/4/03

Decision

I agree with the insurance carrier that the requested medications are not medically necessary.

Rationale/Basis for Decision

Carisoprodol is a sedative muscle relaxant generally used for acute painful musculoskeletal conditions in concert with rest and physical therapy modalities. It is metabolized into Meprobamate, an abusable sedative. Hydrocodone is a narcotic agent, generally used for the management of an acute painful musculoskeletal conditions and peri-operative conditions. Promethazine is an anti-emetic generally used for control of nausea and vomiting associated with anesthesia and post-operative conditions. All of the above medications are generally used for acute painful musculoskeletal conditions and are not indicated for management of chronic pain syndromes. Clinical evidence indicates the superior endplate fracture, a minor self-limited injury, has fully resolved. There is no documentation of exhaustion of conservative measures and treatment including, but not limited to, over the counter non-steroidal anti-inflammatory medications, oral cortico steroids, bracing, and physical therapy emphasizing dynamic spinal stabilization (McKenzie) to manage claimant's chronic pain syndrome. Generally, following use of the above medications for acute painful musculoskeletal conditions, there is documentation of attempts to wean the patient from use of narcotics and sedative type muscle relaxants with dependency risk issues. There is no documentation of any attempt to wean the patient from these medications. The documentation does not support that the continued use of these medications is medically necessary in this clinical setting.